SUPREME HEALTH CARE STAFFING SERVICES, LLC

4401 Atlantic Avenue, 2nd Floor, Suite 221

Long Beach, California, 90807

Tel: 1-562-984-2045; Fax: 1-562-984-2075

Employment Application Packet

Complete this Application Packet and send back by Fax at ***(562) 984****-2075 or email at* ***supremehealthcarestaffing@yahoo.com***

To ensure our compliance with the standards of both our clients and The Joint Commission, Supreme Health Care Staffing Services LLC require the following documentation in our system.

Requirements:

- ☐ **Resume**
  - ☐ explain GAPS IN EMPLOYMENT, if any to avoid delays in your Pre-qualification process
  - ☐ please indicate the City and State plus month and year per work history
  - ☐ also if you speak any Language other than English
- ☐ **Application for Employment**
  - ☐ Supreme Health Care Staffing Services LLC Application Form
  - ☐ Employment History
  - ☐ Emergency Contact
  - ☐ Legal Questionnaire
- ☐ **Employment References** *(3)*
- ☐ **Professional References** *(2)*
- ☐ **Clinical Skills Checklist** *(Completed & Signed)*
- ☐ **Professional Credentials** *(please attach the following when submitting this Application)*
  - ☐ CA Professional license *(front and back copies with signature)*
  - ☐ Driver's License *(front and back)*
  - ☐ Social Security Card *(front and back)*
  - ☐ BLS/CPR *(front and back copies with signature)*
  - ☐ ACLS, PALS, MAB, EKG/Arrhythmia Certification as applicable *(front and back copies with signature)*
  - ☐ Fire and Safety Card *(front and back)*
  - ☐ Diploma *(hospital requirement for education verification)*
  - ☐ Physician Statement, taken within the last 12 months, **Physician Statement with Signature of MD and must state that you are free of communicable diseases and in good physical and mental health (within a year)*
  - ☐ Chest X-ray *(with complete* ***Radiology Report*** *or PPD Test (within a year with* ***Lot No.)***
  - ☐ MMR Vaccine *(within the last 10 years)* or Titer
  - ☐ Varicella Vaccine *(within the last10 years)* or Titer
  - ☐ TDAP vaccine *(within the last 10 years)*
  - ☐ Hepatitis Vaccine *(proof of series within the last 10 years)* or Declination r Titer
  - ☐ Flu/H1N1 Vaccine *(annually)* or Declination
- ☐ **Authorization to Disclose PHI** *(Personal Health Information)*
- ☐ **Background Investigation and Drug Testing Consent** *(10 panel)*
- ☐ **Permanent Tax Home Notification**

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Application for Employment

(Please complete even if attaching a resume)

	_____	____	____/____/____	____-___-_____	_____	____/____/____
Position Applying for	**Professional Lic. No.**	**State**	**Expiration Date**	**Social Security No.**	**Driver License No.**	**Date of Birth**

_____	_____	_____	_____	(_____) _____-_____
Last Name	First Name	Middle Initial	Maiden/Other Names Used	Primary Contact No.

Street Address	Apt. /Unit	City	State	Zip Code	Email Address

(_____) _____-_____	(_____) _____-_____	_____-_____	_____	(_____) _____-_____
Mobile No.	Home Phone No.	Preferred Call Time	Emergency Contact Person	Contact No.

Availability Date:	_____	**Type of Employment: (Please check all that applies)**	_____ Permanent	_____ Contract (8/13+ weeks)	_____ Per Diem
How did you hear about us?	_____ Internet Specify: _____	_____ Paper/Ads Specify: _____	_____ Friend/Associate Specify: _____	_____ Friend/Associate Specify: _____	_____ Other Specify: _____
Are you able to perform basic functions of the position which you are applying for without any restrictions?	_____ YES	_____ NO Please explain: _____			

Education

Graduate Studies	_____	_____	_____	_____/_____	_____/_____
	College/University Name	Address (City & State)	Degree/Field of Study	Start (Month/Year)	End (Month/Year)
Bachelors or Associate Studies	_____	_____	_____	_____/_____	_____/_____
	College/University Name	Address (City & State)	Degree/Field of Study	Start (Month/Year)	End (Month/Year)
Bachelors or Associate Studies	_____	_____	_____	_____/_____	_____/_____
	College/University Name	Address (City & State)	Degree/Field of Study	Start (Month/Year)	End (Month/Year)
High School	_____	_____	_____	_____/_____	_____/_____
	High School Name	Address (City & State)	Degree/Field of Study	Start (Month/Year)	End (Month/Year)

Healthcare Unit & Specialty

_____	_____	_____/_____	_____/_____	_____	_____	_____/_____	_____/_____
Primary specialty unit	Years of exp.	Start (Month/Year)	End (Month/Year)	**2nd specialty unit**	Years of exp.	Start (Month/Year)	End (Month/Year)
_____	_____	_____/_____	_____/_____	_____	_____		_____/_____
3rd specialty unit	Years of exp.	Start (Month/Year)	End (Month/Year)	**4th specialty unit**	Years of exp.	Start (Month/Year)	End (Month/Year)

Certifications *(Please attach a copy of each including front and back copies)*

	BCLS/CPR	Exp. Date:	___/___		CCRN	Exp. Date:	___/___		CHEMO	Exp. Date:	___/___
	ACLS	Exp. Date:	___/___		ONCO	Exp. Date:	___/___		EKG Cert.	Exp. Date:	___/___
	NRP	Exp. Date:	___/___		MAB/CPI	Exp. Date:	___/___		Fire & Safety	Exp. Date:	___/___
	PALS	Exp. Date:	___/___		TNCC	Exp. Date:	___/___		CNOR	Exp. Date:	___/___
	FHM	Exp. Date:	___/___		PICC	Exp. Date:	___/___		Other: _____	Exp. Date:	___/___

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Employment History/Verification Covering Minimum of 5 Years of Work & Others

________________	________________	____	____/____/____	____________________________	____/____/____
Position Applying for	**Professional Lic. No.**	**State**	**Expiration Date**	**Healthcare Professionals Name**	**Date**

(Please list in order, most recent first and explain gaps in employment if any)

Period:	to	**Type of employment:**	
Facility name:		**Agency Name:**	
Facility location:		**Reason for leaving**	
Position held:		**Remarks:**	
Unit/Floor/Dept:			
Supervisors name:			
Supervisors no.:		**Verified by:**	

Period:	to	**Type of employment:**	
Facility name:		**Agency Name:**	
Facility location:		**Reason for leaving**	
Position held:		**Remarks:**	
Unit/Floor/Dept:			
Supervisors name:			
Supervisors no.:		**Verified by:**	

Period:	to	**Type of employment:**	
Facility name:		**Agency Name:**	
Facility location:		**Reason for leaving**	
Position held:		**Remarks:**	
Unit/Floor/Dept:			
Supervisors name:			
Supervisors no.:		**Verified by:**	

Period:	to	**Type of employment:**	
Facility name:		**Agency Name:**	
Facility location:		**Reason for leaving**	
Position held:		**Remarks:**	
Unit/Floor/Dept:			
Supervisors name:			
Supervisors no.:		**Verified by:**	

Period:	to	**Type of employment:**	
Facility name:		**Agency Name:**	
Facility location:		**Reason for leaving**	
Position held:		**Remarks:**	
Unit/Floor/Dept:			
Supervisors name:			
Supervisors no.:		**Verified by:**	

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Employment History/Verification Covering Minimum of 5 Years of Work & Others

____________________	_________________	____	____/____/____	______________________________	____/____/____
Position Applying for	**Professional Lic. No.**	**State**	**Expiration Date**	**Healthcare Professionals Name**	**Date**

(Please list in order, most recent first and explain gaps in employment if any)

Period:		**to**		**Type of employment:**	
Facility name:				**Agency Name:**	
Facility location:				**Reason for leaving**	
Position held:					
Unit/Floor/Dept:				**Remarks:**	
Supervisors name:					
Supervisors no.:				**Verified by:**	

Period:		**to**		**Type of employment:**	
Facility name:				**Agency Name:**	
Facility location:				**Reason for leaving**	
Position held:					
Unit/Floor/Dept:				**Remarks:**	
Supervisors name:					
Supervisors no.:				**Verified by:**	

Period:		**to**		**Type of employment:**	
Facility name:				**Agency Name:**	
Facility location:				**Reason for leaving**	
Position held:					
Unit/Floor/Dept:				**Remarks:**	
Supervisors name:					
Supervisors no.:				**Verified by:**	

Period:		**to**		**Type of employment:**	
Facility name:				**Agency Name:**	
Facility location:				**Reason for leaving**	
Position held:					
Unit/Floor/Dept:				**Remarks:**	
Supervisors name:					
Supervisors no.:				**Verified by:**	

Period:		**to**		**Type of employment:**	
Facility name:				**Agency Name:**	
Facility location:				**Reason for leaving**	
Position held:					
Unit/Floor/Dept:				**Remarks:**	
Supervisors name:					
Supervisors no.:				**Verified by:**	

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Name: _____ Date: _____

Position Applied For: _____

LEGAL QUESTIONNAIRE

Have you ever:

1) . . . been named as a defendant in a malpractice action? ◯ Yes ◯ No If yes, when? _____

Who was your employer at that time? _____

2) . . . had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished?
◯ Yes ◯ No If yes, when? _____ In what state? _____

3) . . . been licensed or practiced professionally under a different name? ◯ Yes ◯ No

If yes, under what name? _____ and what state? _____

4) Are you eligible to work in the U.S.? ◯ Yes ◯ No Alien ID number: _____ (if applicable)

5) . . . been denied a license? ◯ Yes ◯ No If yes, what state? _____ when? _____

What reason? _____

6) . . . been convicted by misdemeanor, felony including traffic violations? ◯ Yes ◯ No

If yes, when? _____ in what state? _____ What county? _____

(this includes any offense where you were found guilty, plead guilty or plead nolo contendere (no contest). You may omit: a conviction of misdemeanor while under the age of 18, if the records were sealed under the Penal code 1203.45b. Any conviction specified in Health and Safety code section 11361.5 which pertains to various marijuana offenses (a conviction will not necessarily disqualify you from consideration for employment).

7) . . . been arrested and are you out on bail on your own recognizance and still awaiting trial? ◯ Yes ◯ No

8) . . . been released or discharged from employment or resigned to avoid such release or discharged? ◯ Yes ◯ No

If yes, please provide dates and circumstances? _____

_____

_____

9) . . . had your driver's license suspended or revoked? ◯ Yes ◯ No If yes, when? _____

Please explain why? _____

My signature certifies that all information contained within my application is correct and maybe verified by Supreme Health Care Staffing Services LLC in compliance with the California Law. It also acknowledges that I am aware that it is my responsibility to review and policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Applicant's Signature: _____ Date: _____ Position: _____

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Application for Employment

Supreme Health Care Staffing Services LLC ("Company") is an Equal Opportunity Employer. All applicants are considered for employment regardless of age, race, gender, religion, national origin, disability, marital status or any other factor prohibited by law.

Please take a moment to review and acknowledge your understanding and acceptance of this Agreement.

- I certify that the information provided on this Application is accurate. I understand that the withholding of information or the giving of false information on this Application may result in a refusal to hire or disciplinary action including, but not limited to, termination. I understand and agree that if I am offered employment by the company, it will be on an at-will basis. This means that either the Company or I may terminate the employment relationship at any time, for any reason, with or without cause or notice. I also understand and agree that only an officer of the Company can enter into an agreement on any other terms and he/she can only do so in writing signed by the officer and me. I have read the above before signing this Application.

- I further understand and waive my right of privacy in this investigation and release and hold harmless Supreme Health Care Staffing Services LLC from any liability.

- I agree that any decision to hire me is contingent upon the results of my report, and certify that all statements and answers on my Application, resume, or interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will cause for disqualification and immediate termination of my employment. I further authorize Supreme Health Care Staffing Services LLC to check my conviction record as needed, on a continuous basis as it relates to my employment.

- I authorize Supreme Health Care Staffing Services LLC to release any employment records, including health records submitted to them in consideration of employment at the customer facility where I am being placed at.

Applicant's Full Name: _____

Applicant's Signature: _____ Date: _____

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Employment Reference Check #1

** Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the reference such as Charge RN, RN Supervisor, DON, Nurse Manager. This reference MUST be someone who the candidate reported to directly on the floor unit.**

Applicant's Name _____ Position Held _____

Dates of Employment: From/To _____ Current/Former Employer _____

City _____ State _____ Supervisor's Name _____

☐ I hereby give permission to the above named employer to release information to Supreme Health Care Staffing Services LLC regarding my performance while employed at that facility.

Applicant's Signature: _____ Date: _____

Employment History

The person above is applying for an employment with Supreme Health Care Staffing Services LLC and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ☐ Yes ☐ No

Personal Evaluation	Excellent	Above Average	Average
Demonstrates technical proficiency	☐	☐	☐
Consistent in quality of work	☐	☐	☐
Adheres to facility policies and procedures	☐	☐	☐
Flexibility and adaptability	☐	☐	☐
Attendance and punctuality	☐	☐	☐
Overall professionalism	☐	☐	☐

Comments: _____

_____

Employer's Signature _____ Title _____ Date _____

Note to the Staffer--Please indicate if this is a Verbal Verification: _____

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Employment Reference Check #2

** Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the reference such as Charge RN, RN Supervisor, DON, Nurse Manager. This reference MUST be someone who the candidate reported to directly on the floor unit.**

Applicant's Name _____ Position Held _____

Dates of Employment: From/To _____ Current/Former Employer _____

City _____ State _____ Supervisor's Name _____

☐ I hereby give permission to the above named employer to release information to Supreme Health Care Staffing Services LLC regarding my performance while employed at that facility.

Applicant's Signature: _____ Date: _____

Employment History

The person above is applying for an employment with Supreme Health Care Staffing Services LLC and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ☐ Yes ☐ No

Personal Evaluation	Excellent	Above Average	Average
Demonstrates technical proficiency	☐	☐	☐
Consistent in quality of work	☐	☐	☐
Adheres to facility policies and procedures	☐	☐	☐
Flexibility and adaptability	☐	☐	☐
Attendance and punctuality	☐	☐	☐
Overall professionalism	☐	☐	☐

Comments: _____

_____

Employer's Signature _____ Title _____ Date _____

Note to the Staffer--Please indicate if this is a Verbal Verification: _____

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BACKGROUND INVESTIGATION and DRUG/ ALCOHOL TESTING AUTHORIZATION

I, _____ , hereby authorize ***Supreme Health Care Staffing Services LLC*** and/or its agents to make an independent investigation of my background, references, characters, past employment, education, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications for employment now and, if applicable, during the tenure of my employment with Company.

As part of the application process, I understand that according to the ***Supreme Health Care Staffing Services LLC*** Substance Abuse Policy and Control Program, I am required to participate in a fit for duty examination, including urine and/or blood screens or other medical examinations for alcohol, drugs and controlled substances. I understand that if the test results indicate that I have been consuming any illegal or non-prescribed drugs, these findings will disqualify me from employment with ***Supreme Health Care Staffing Services LLC***.

I also understand as a condition of any offer of employment, that I will be required to participate in any requested future fit for duty examinations based upon "reasonable suspicion", "for cause", or any other lawful reason(s). These tests may be, but are not limited to urine, and/or blood screens or other medical examinations and will test for any use of alcohol, drugs or controlled substances.

I also understand, as a condition of employment, that I may be subject to random drug testing. I consent to these future examinations, including specimen collection and the release of test results to the company. I understand that if at any time refuse to submit to, release the results of, these examinations or if the test results indicate that I was under the influence of alcohol or that I was consuming any illegal or non-prescribed drugs, these findings will result in immediate removal from the work site and the appropriate disciplinary action, up to and including termination.

I further understand that all drug/alcohol testing will be conducted by a certified laboratory with all data to be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy.

I consent to the release of the results of any drug test to authorized representatives of ***Supreme Health Care Staffing Services LLC*** for appropriate review. I release ***Supreme Health Care Staffing Services LLC*** and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

_____ _____
Signature Today's Date

_____ _____
Please Print Full Name Please Print Other Names You Have Used

_____
Social Security Number - Your social security number will be used to confirm your identity for completing the investigation testing.

_____
Date of Birth - The Age Discrimination in Employment Act of 1967 prohibit discrimination on the basis of age with respect to individual who are at least 40 years of age. Your date of birth is required on this form in order to confirm your identity for purposes of completing an accurate background investigation, and is not provided at the hiring with consideration of our application for employment.

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Authorization for Use Disclosure of Health Information

I authorize the use or disclosure of my health information as described below.

1. Person(s) or class of persons authorized to use or disclose the information: (Note: e.g. Name of Provider, lab, etc. that will disclose the information)

Please List: _____

2. Person(s) or class of persons authorized to receive the information: ***Supreme Health Care Staffing Services LLC*** **and its authorized employees only**

3. Description of information that may be used or disclosed: (Note: e.g. all information related to a specific test or type of evaluation)

Please List: _____

4. The information will be used or disclosed for the following purposes:
For use by ***Supreme Health Care Staffing Services LLC*** and its clients in evaluating my qualifications for employment opportunities and related activities.

5. I understand that if the person or entity that receive the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization at any time by sending a written request to the party identified in paragraph 1, except to the extent that action has been taken in reliance on this authorization.

7. This authorization expires _____ [Please insert a date or described the termination of an event or activity related to the individual or to the purpose of the authorization. This date relates to the termination of the right to the provider to disclose the information and not to ***Supreme Health Care Staffing Services LLC*** right to use this information, which, once the information is disclosed, does not terminate].

☐ I acknowledge, understood and accept this Agreement/Statement.

_____ _____

Signature Date

_____

Applicant's Full Name

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B**	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . .	**G**	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**	

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

SUPREME HEALTH CARE STAFFING SERVICES LLC
PAYROLL AGREEMENT

Payroll Authorization	*Please initial the appropriate response* _____ Direct Deposit _____ Mail _____ Pick-up	I, _____ understand that Supreme Health Care Staffing Services LLC is not responsible for the delivery of my check after it is mailed, and that any delay in delivery is not the fault of the Registry. I also accept the responsibility of the bank charges for having a Stop Payment Order placed on lost checks. (The charge will be the current fee levied by the bank upon which the payroll checks are drawn.)
Promissory Note	**I, _____, agree to return to Supreme Health Care Staffing Services LLC, within 72 hours, any payment received in excess of my actual hours worked. This overpayment will be returned by working a shift in which an adjustment can be made to my next paycheck; otherwise, I agree to write a personal check or money order made payable to Supreme Health Care Staffing Services LLCfor the amount due. This also applies to any expenses related to my employment with the company such as but not limited to drug screen, physical, TB test, etc.**	
Travel Nurse *Address more than 50 miles from the assignment.*	*Please initial the appropriate response.* _____ YES _____ NO	• Stipend will be paid base on IRS Per Diem Rates in accordance to publication 1542. • Stipend is paid every Thursday of the following week in accumulation of all shift worked on prior cut-off, Sunday to Monday. Remainder is paid regularly in accordance to the company's compensation schedule.

In case of any changes in the future, please inform Supreme Health Care Staffing Services LLC. as soon as possible.

*All payroll checks must be cashed within **30 days** from the date on the check.*

_____ _____

Employee Signature Date

4401 Atlantic Avenue, Ste. 221, Long Beach, CA 90807 Tel: 562.984.2045 Fax: 562.984.2075

Website: www.supremehealthcarestaffing.com Email: supremehealthcarestaffing@yahoo.com

Name: _____ Classification: _____

SUPREME HEALTH CARE STAFFING SERVICES LLC
CA MEAL WAIVER FOR EMPLOYEES IN THE HEALTHCARE INDUSTRY

(Complete only **ONE** of the following)

MEAL PERIOD WAIVER

Pursuant to California law, I understand that I am entitled to take two meal periods if I work in excess of 10 hours. I also understand that California law entitles me to waive one of those two meal periods. Therefore, in accordance with California law, I voluntarily agree to waive one meal period each day that I work in excess of 10 hours. Based on this waiver, I understand that I will receive only one duty-free meal period for which I will not be compensated. I agree to indicate on my time sheet if I fail to take any other required meal period or rest period. I will be paid for all other working time, including the second meal period that I waived. I acknowledge that this Meal Period Waiver will remain in effect until the earlier of: (x) the last day of a 30-day break following your contract end date or (y) until I revoke it by providing a written notice of such revocation to the Company with at least one day's prior written notice.

I acknowledge that I (i) have read this waiver; (ii) have had an opportunity to ask the Company any questions I may have with respect hereto and (iii) understand the terms of this waiver and agree hereto.

Signature: _____ Date: _____

DECLINATION OF MEAL PERIOD WAIVER

Pursuant to California law, I understand that I am entitled to take two meal periods if I work in excess of 10 hours. I also understand that California law entitles me to waive one of those two meal periods, however, I do not wish to waive any meal periods. Accordingly, I agree to take all meal periods I am legally required to take when working in excess of 10 hours. I agree to indicate on my timesheet if I fail to take any required meal period.

I acknowledge that I (i) have read this agreement, (ii) have had an opportunity to ask the Company many questions I may have with respect hereto and (iii) understand the terms of this waiver and agree hereto.

Signature: _____ Date: _____

✉4401 Atlantic Avenue Ste. 221, Long Beach, CA 90807 ☏ 562.984.2045 🖷 562.984.2075

Website: www.supremehealthcarestaffing.com Email: supremehealthcarestaffing@yahoo.com

Mask-Fit/TB Questionnaire
Quantitative (QNFT)

Employee Name _____ Dept _____ Date _____

DOB _____ Job Title _____ Sex: ☐ Male ☐ Female Ht: _____ Wt: _____

FIT TEST QUESTIONNAIRE

1. Have you ever worn a respirator? ☐ Yes ☐ No
   - If yes, what type? _____
2. When was your last Mask fit test? _____
3. Any breathing difficulties when wearing a mask? ☐ Yes ☐ No
4. Any anxiety or claustrophobia when wearing a mask? ☐ Yes ☐ No
5. When working, do you wear eyeglasses? ☐ Yes ☐ No
   - Or, contact lenses? ☐ Yes ☐ No

Comments _____

I certify that I have been instructed upon the proper application, maintenance, disposal, and limitations of a respirator.

Employees Signature: _____

STEPS

1.	Normal Breathing	☐ Pass	☐ Fail
2.	Slow Breaths	☐ Pass	☐ Fail
3.	Turn head left and right	☐ Pass	☐ Fail
4.	Move head up and down	☐ Pass	☐ Fail
5.	Count to 100 out loud	☐ Pass	☐ Fail
6.	Grimacing – smile frowning	☐ Pass	☐ Fail
7.	Bending over	☐ Pass	☐ Fail
8.	Normal Breathing	☐ Pass	☐ Fail

☐ Technol N-95, Size _____
☐ Moldex N-95 Respirator, Size _____
☐ 3M N-95 Respirator, 1860 Size _____
☐ Other _____ Size _____

Comments _____

Validator's Signature: _____

TB QUESTIONNAIRE

1.	Do you have a history of positive PPD skin test?	☐ Yes	☐ No	Date: _____
2.	Have you ever received INH (isoniazid) treatment?	☐ Yes	☐ No	Date: _____
3.	Did you have a chest x-ray at any time in the past?	☐ Yes	☐ No	Date: _____
4.	Have you had BCG immunization before?	☐ Yes	☐ No	Date: _____
5.	Productive cough which has lasted at least three weeks?	☐ Yes	☐ No	
6.	Weight loss without dieting	☐ Yes	☐ No	
7.	You have a sign or symptoms of the following:			
a.	Night sweats?	☐ Yes	☐ No	
b.	Loss of appetite (anorexia)?	☐ Yes	☐ No	
c.	Coughing up blood?	☐ Yes	☐ No	
d.	Tire easily?	☐ Yes	☐ No	
e.	Chest pain?	☐ Yes	☐ No	
f.	Other symptoms? (if "Yes", please specify)	☐ Yes	☐ No	Specify: _____
8.	Are you a recent PPD skin test converted (w/in 2yrs)?	☐ Yes	☐ No	
9.	Are you in close contact w/ person(s) who has TB?	☐ Yes	☐ No	
10.	Do you have HIV infection?	☐ Yes	☐ No	
11.	Do you use injectable drugs?	☐ Yes	☐ No	

Persons w/ altered immune response because of immune deficiencies, HIV infection, leukemia, lymphoma, generalized malignancy, or immunosuppressive therapy w/ corticosteroids, alkylating drugs, antimetabolities, radiation, or chronic debilitating desease.

Signature: _____

Date:_____

TB Skin Test: 5Tu/.1ml administered intradermally and read 48 to 72 hours later.

Site LFA ☐
_____ Site RFA ☐ _____ Reading #1 _____ _____ mm induration
Date Med/Lot Date mm

Authorized Signature:

_____
Nurse Practitioner/MD/PA/RN/LVN

TB Skin Test: 5Tu/.1ml administered intradermally and read 48 to 72 hours later.

Site LFA ☐
_____ Site RFA ☐ _____ Reading #2 _____ _____ mm induration
Date Med/Lot Date mm

Authorized Signature:

_____
Nurse Practitioner/MD/PA/RN/LVN

Supreme Health Care Staffing Services LLC; 4401Atlantic Avenue, Ste 221, Long Beach, CA 90807

T: (562) 984-2045 F: (562) 984-2075
www.supremehealthcarestaffing.com

Name: _____ Classification: _____ Date: _____

Answer Sheet for Color Blindness Test (Ishihara Test)

To retrieve test online please go to:
http://www.redcarlifeboat.org.uk/Pages/Misc/Ishihara%20Test%20for%20Color%20Blindness.htm

1. Please sit approximately 75cm from your monitor, with each circle set at eye level.
2. Preferably have mild natural light and no glare on your screen. Interior lights and glare can alter the color of the pictures.
3. Identify the hidden number on each plate.
4. Please record the answers below.

Top Left _____ Top Right _____

Middle Left _____ Middle Right _____

Bottom Left _____ Bottom Right _____

The Ishihara Test for Color Blindness has been completed by the above named employee.

_____ _____
Signature of Agency Representative Date

✉ Supreme Health Care Staffing Services LLC; 4401 Atlantic Avenue Ste. 221, Long Beach, CA 90807
☎ 626.432.1999 🖷 626.432.1991

Website: www.supremehealthcarestaffing.com Email: supremehealthcarestaffing@yahoo.com

Name: _____ Classification: _____

SUPREME HEALTH CARE STAFFING SERVICES LLC VACCINE DECLINATION

Decline Hepatitis B Vaccine?

☐ Yes (Please read the statement and sign below)

☐ No (Please provide us proof of vaccination or titer)

I understand that due to my exposure to blood or other potentially infectious material, I may be at risk acquiring Hepatitis B virus (HBV) infection. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will get the vaccination from my physician.

Signature: _____ **Date:** _____

Decline Tetanus, Diphtheria and Pertussis (TDAP) Vaccine?

☐ Yes (Please read the statement and sign below)

☐ No (Please provide us proof of vaccination/booster)

I understand that due to my clinical placement, I may be at risk of exposure to Tetanus, acellular pertussis also known as Whooping Cough, and diphtheria. I have been advised to be vaccinated with the TDAP, however I decline the vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease, and may also expose others to the disease if I become ill.

I have read the above information and understand that I may be excluded from my clinical placement for a designated length of time if I am exposed to TDAP. I also understand that I am required to report any possible exposures to Supreme Health Care Staffing Services LLC as soon as I am aware of being exposed to TDAP.

Signature: _____ **Date:** _____

Decline H1N1/Flu Vaccine?

☐ Yes (Please read the statement and sign below)

☐ No (Please provide us proof of vaccination)

My employer, Supreme Health Care Staffing Services LLC, has recommended that I receive influenza/ H1N1 vaccination in order to protect myself and the patients I serve.

I acknowledge that I am aware of the following facts: (1) Influenza/H1N1 is a serious respiratory disease and is recommended for me and all other healthcare workers to prevent influenza/H1N1 disease and its complications, including death. (2) If I contract influenza/H1N1, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza/H1N1 infection to patients in this facility. (3) I understand that the strains of virus that cause influenza/H1N1 infection change almost every year, which is why a different influenza/H1N1 vaccine is recommended each year. (4) The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including patients in this healthcare setting, my co-workers, my family, and my community. Despite these facts, I am choosing to decline influenza/H1N1 vaccination right now. I understand that I may change my mind at any time and accept influenza/H1N1 vaccination, if vaccine is available.

Signature: _____ **Date:** _____

✉4401 Atlantic Avenue, Ste. 221, Long Beach, CA 90807 ☎ 562.984.2045 🖷 562.984.2075

www.supremehealthcarestaffing.com supremehealthcarestaffing@yahoo.com

4401 Atlantic Avenue, Suite 221, Long Beach, CA 90807
Tel: (562) 984-2045 * Fax: (562) 984-2075
supremehealthcarestaffing@yahoo.com

DATE: _____/_____/ 2014 CLIENT/FACILITY: _____

Instruction to Employee

1. Complete all sections of Time Slip.
2. Have client (representative) sign.
3. Fax a copy at the end of the week.

SIGN-IN SHEET

DATE	NAME	TITLE	UNIT	IN	MEAL	OUT	TOTAL	SIGNATURE	Authorized by: SIGNATURE

COMMENTS

_____

_____

I CERTIFY THAT THE HOURS SHOWN ABOVE ARE CORRECT AND WORK WAS PERFORMED IN A SATISFACTORY MANNER.

_____

CLIENT SIGNATURE

SUPREME HEALTH CARE STAFFING SERVICES LLC ANNUAL REVIEW OF OSHA/JCAHO GUIDELINES

I have received the Employee Manual and Annual Review:

MISSION STATEMENT AND POLICY & PROCEDURES

- ✓ Body Mechanics
- ✓ Fire and Electrical Safety
- ✓ Radiation Safety
- ✓ Hazardous Materials Communications
- ✓ Infection Control / Bloodborne Pathogens
- ✓ Emergency Preparedness
- ✓ General Safety / Security
- ✓ Physical Assault – Work Place Violence
- ✓ Domestic Violence
- ✓ Suspected Child Abuse and Neglect
- ✓ Sexual Assault
- ✓ Suspected Elder/Dependent Adult Abuse and Neglect Directives
- ✓ Patient Education
- ✓ Organ and Tissue Donation
- ✓ Restraint Devices
- ✓ Quality Improvement and Risk Management
- ✓ Do not Send Prevention/DNU Abbreviations
- ✓ Pain Management Survey
- ✓ Cultural Diversity
- ✓ Conscious Sedation
- ✓ Age Related Nursing Care Issued
- ✓ Drug Free Workplace
- ✓ Blood Glucose Monitoring
- ✓ Organ/Tissue Donation
- ✓ Patient Fall Prevention
- ✓ Suicidality and Suicidal Assessment
- ✓ Medication Error Prevention
- ✓ Job Description
- ✓ Capping
- ✓ Patient Rights and Advance
- ✓ National Patient Safety Goals
- ✓ Code of Conduct
- ✓ Confidentiality
- ✓ Nail Policy
- ✓ HIPAA
- ✓ End of Life Care

IN SERVICE TO THE FOLLOWING:

- ✓ Client and Agency confidentiality Policy
- ✓ Agency handbook Abuse Statement
- ✓ "Do Not Use List" abbreviations
- ✓ JCAHO Patient Safety Goals
- ✓ 2009 Deficit Reduction Act (DRA) Policies & Procedures
- ✓ 1991 Patient Self Determination Act
- ✓ Applicant Statement
- ✓ Personnel Guidelines
- ✓ Conditions of Employment
- ✓ Child, Elder and Domestic Violence
- ✓ Disaster Preparedness/Earthquake
- ✓ Orientation to: Client & Company
- ✓ Nursing Code of Conduct
- ✓ California State Code 707007
- ✓ Patient Bill of rights
- ✓ Hand Hygiene & Fingernails/Artificial Nails Guidelines

Printed Name:_____ Signature:_____ Date:_____

Supreme Health Care Staffing Services LLC Staff:

Staff Name: _____ Signature:_____ Date:_____